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ABSTRACT

This report, prepared by the National Clearinghouse for Drug Abuse Information, discusses the Free Clinic Movement--its philosophy, characteristics, background, and problems. The Free Clinic Movement developed because the existing health care system was not providing services to a large number of racial, philosphical, and cultural minorities due to overcrowded hospitals, fear of legal entanglements, and insufficient experience with some of the "street" diseases of these groups. The clinics have shown that adequate medical care can be provided at minimal cost utilizing nonprofessional, paraprofessional, and professional staff. There are four basic types of clinics in existence: neighborhood clinics, street clinics, youth clinics, and sponsored clinics. The report details the general operations of these clinics, i.e., physical layout, staffing, services, and funding, and offers both support and criticism for existing facilities. (Author/PC)

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SERIES 27, NO.1

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The National Clearinghouse for Drug Abuse Information recognizes the need for clarifying some of the more complex issues in drug abuse by gathering the significant research findings on each subject and developing fact sheets on the problem. These fact sheets, which are part of the Clearinghouse Report Series, present information about treatment modalities, the pharmacology and chemistry of various drugs of abuse, and opinions and practices of recognized authorities in the field. This publication was prepared by the Clearinghouse and Donald R. Wesson Associates, 527 Irving Street, San Francisco, California 94122, under Contract No. HSM 42-72-99.

FREE CLINICS

Free clinics are a relatively new concept in the health care delivery system. The word "free" as applied to this concept means much more than "no charge for services received." The philosophy of the Free Clinic Movement is that "free" is a state of mind, rather than an economic term. Characteristics of the free clinic philosophy are: health care is a right rather than a privilege; no proof of financial need is required, thus differentiating free clinics from charity facilities; a minimum of red tape is implied; and conventional labels and value systems applied to individuals who may be regarded as "deviant" by the general society are disregarded. Rather than focus on treating a specific disease, emphasis is on the entire individual. No fee, no patronizing, and no moralizing on the staff's part are essential components of the free clinic philosophy.

Since 1967 when the first free clinic opened its doors to the youth of San Francisco, over 250 free clinics have begun operations across the country, serving over two million patients each year. These clinics offer medical and health care to members of a community who need treatment for problems ranging from the common cold to venereal disease and drug addiction.

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Smith, Bentel, and Schwartz (1971) define a free clinic as an operation that must include the following:

1) Direct delivery of either medical, dental, psychological or drug rehabilitation services.
2) Presence of a professional relevant to the service provided.
3) Services available to everyone.
4) In general, no direct charges (although small charges for specific services or donations may be requested).
5) Specified hours of service.
6) Care provided from a specialized facility.

Bloomfield et al. (1971) of the Health Policy Advisory Center in New York analyzed the Free Clinic Movement, and felt its guiding principles could be summarized as follows:

1) Health care is a right and should be free at the point of delivery.
2) Health services should be comprehensive, unfragmented and decentralized.
3) Medicine should be demystified. Health care should be delivered in a courteous and educational manner. When possible, patients should be permitted to choose among alternative methods of treatment based upon their needs.
4) Health care should be deprofessionalized. Health care skills should be transferred to worker and patient alike; they should be permitted to practice and share these skills.
5) Community-worker control of health institutions should be instituted. Health care institutions should be governed by the people who use and work in them.

History and Background

In the mid 1960's, a new cultural movement started in major cities across the United States, and San Francisco became one of the largest gathering points for members of this movement. The 'hippie' movement was predominantly made up of young people, most of whom came from middle-to upper-class American families. Dissatisfied with what they thought was a materialistic society, they rejected traditional societal values and began a search for a new way of life.

In 1967, thousands of young people migrated to the Haight-Ashbury section of San Francisco as part of this search. The already over-crowded Haight became more over-crowded, and health and sanitary conditions were such that hepatitis, venereal disease and other communicable diseases had reached almost epidemic proportions.

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Those young people who sought medical treatment were often turned away from local hospitals. Hospital staff members found it difficult to deal with the long-haired, barefooted, unclean and unemployed youth. Additionally, although drug use was a major part of the 'hippie' lifestyle, the problems associated with its use and treatment were almost unknown to the hospital staff.

Many of these youths, however, would not even attempt to seek treatment through the traditional medical channels because they were runaways and could not chance the probable involvement of their parents or police. Therefore, to minister to the medical needs of this new community, the Haight-Ashbury Free Clinic was opened offering outpatient services and a 'calm center' for those experiencing bad trips from the use of LSD or other hallucinogens. Between the years 1967 and 1969, about 70 free clinics were established throughout the country to meet the medical needs of their own 'hippie' or street communities.

The National Free Clinic Council (1304 Haight Street, San Francisco, California 94117) was formed in 1968 to provide basic information to those starting or already operating free clinics and to facilitate discussion and information exchange among the various clinics. The Council has thus far sponsored two Symposiums; the first in January 1970, the purpose of which was to discuss the possibilities of a coordinative effort between existing free clinics; and the second in January 1972, where views and opinions were shared among more than 1,000 free clinic workers from all over the country.

Types of Free Clinics

Through the discussions at the First Free Clinic Symposium, it became apparent that very little was known generally about the services offered, staffing patterns, clientele, funding, and organization of the various free clinics. Thus, Dr. Jerome L. Schwartz, a member of the Council, headed the First National Survey of Free Medical Clinics in an attempt to answer some of the questions posed at the Symposium. Dr. Schwartz found, among other things, that there were four basic types of clinics in existence: 1) neighborhood clinics; 2) street clinics; 3) youth clinics; and 4) sponsored clinics.

Neighborhood Clinics - These clinics are started by either a group of residents in a specific neighborhood or housing project or by a political organization (for example, Black Panthers, Young Lords, Young Patriots, and Latin American Defense Organization). Many of these centers serve minority persons in areas where few health resources are available. Neighborhood clinics provide medical care to families, with most patients being young children, pregnant women, or older people from the immediate neighborhood; only a few offer care for hard drug problems. Mental health programs are sometimes offered, as are 'rap' programs. Almost all of these clinics

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have community boards, with neighborhood residents participating in policy-making.

Street Clinics - Drug and mental health services are major components of street clinics. In addition, a variety of other health problems related to drugs and the 'hippie' lifestyle are treated, such as venereal disease, pregnancy testing, urinary infections, and hepatitis. Abortion and legal counseling are also offered. Great emphasis is placed on psychological services for mental health problems; psychological problems among patients tend to be serious, and almost all street clinics have volunteer psychiatrists on staff. The largest age group of patients includes the 19 to 24-year-olds, followed by the 16 to 18-year-old group; clinics have few patients who are young children or people over 35 years of age. Many street clinics are located near a college or university campus or in the 'hippie' section of town. Generalizations cannot be made concerning the decision-making process. Many do not have a board of directors, some have an inactive board, and some clinics have functioning boards composed of community people, staff, street people and students. Policies are often decided by the staff, the administrator, or the medical director.

Youth Clinics - These clinics are generally organized by adults, service clubs, or official boards, such as mayor's committees or drug councils, because of community concern about drug use among high school students. Most youth clinics have a policy board composed of city officials, housewives, businessmen and professionals. A few clinics also have students on their boards. Financial support may be provided by the community and offer drug services limited primarily to education and counseling. Other types of counseling are more prevalent; problems with parents, school, etc. The largest group of patients are the 16 to 18-year-olds. Patients come from all over the city and suburbs, and unlike street clinics, transients are rare. The few clinics of this type that cater to very young children do not offer drug-related services.

Sponsored Clinics - These clinics are modeled after street clinics, serving the same type of patients; however, the average ages of these patients are lower than those of the street clinics. Sponsored clinics, such as those run by the Los Angeles Health Department, are basically the only type of clinics offering salaries to the professionals, who are paid on an hourly basis. Policy-making is carried out by the paid professional staff.

General Operations: Physical Layout, Staffing, Services, and Funding

The general characteristics of free clinics have changed little since the movement began. They are located in an area of the city where the needs for their services are greatest -- mostly in an inner-city ghetto area or near a large university. Whether operating from a store-front, an old house or a church basement, most free clinics have a common setup. Although some clinics receive financial support for their operations, frequently everything is donated, - the furniture, the medical equipment and supplies, and the drugs used in treatment by the medical staff.

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Donations are received from pharmaceutical companies, equipment manufacturers, local hospitals and doctors' offices, the supporting community, the staff, and the patients themselves.

Staff at free clinics consists mainly of volunteers. In a few clinics the receptionist or secretary may receive a minimal salary. A few professionals may also be salaried, but receive minimal pay ,usually by hours worked. Budgets are small, and any money remaining after rent payments and normal expenses is used for equipment, medicines, or expansion of services.

The professional staff is comprised of physicians, nurses, psychiatrists, counselors, pharmacists, dentists, lawyers, and lab technicians -- the number of each depends on the types of services offered. Nonprofessionals and paraprofessionals make up the rest of the staff. Often, these are former patients of the clinic, willing to exchange some of their time for the medical services they have received. As with most volunteer organizations, the personnel turnover rate is high. Dr. Arnold Leff, ex-director of the Cincinnati Free Clinic, offers this explanation in an article by Eisenberg (1972) as one cause for the turnover rate: "It's exciting at the start, but when that wears off--we call it the Burnout Syndrome--it becomes work. And when it's work, who wants to do it for free?"

Although there is no established fee for services rendered, many clinics ask for donations from the patients to help pay for the needs of the clinic. Small charges may be made for services such as pregnancy tests, to cover the lab fee. A donation can on the receptionist's desk is a common sight.

One of the basic philosophies of the Free Clinic Movement is the demystification and deprofessionalization of medicine. This objective is demonstrated by the often emphasized transfer of skills -- the delegation, within the units of the law, of minor professional skills to the paramedic workers at the clinic. In most cases, this transfer of skills is learned in an over-the-shoulder apprentice fashion. Not only does this practice aid the physicians on duty, but also serves as a learning experience for the nonprofessional volunteer. Many free clinics conduct classes in these skills for their volunteers.

Aside from general medical and psychological services, many free clinics offer additional medical and non-medical services, depending on the needs of the community. Services may include day care, 'crash pads', job placement services, switchboards, legal and draft counseling, free stores which distribute clothing and food, or screening for specific diseases in the community, such as T.B. or sickle cell anemia.

The need for gynecologic services -- pap smears, pregnancy testing, abortion counseling, birth control, venereal disease treatment -- has become so great that some clinics set aside one evening each week to deal with only these types of

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patient visits. An extension of this is the development of women's clinics, set up to deal not only with the physical needs of women, but also with their psychological needs.

Free clinics also serve as social institutions where alienated youth can find a place to participate in a meaningful work experience. Many young people have acquired skills as medical paraprofessionals, drug counselors, administrators of medical programs, lab assistants and a variety of other jobs which have helped them become constructive members of their community and of the dominant society as well. Free clinic staff, by working with the community, can also serve as a valuable source of public health education and preventive street medicine, especially in the area of drug use and abuse.

There are a number of ways free clinics can obtain financial support for their operations: the Federal Government, health departments, the community (unions, individuals, churches, and professional groups), industry, voluntary health associations, private foundations, and hospitals or medical schools.

Observations: Support and Criticism

The Free Clinic Movement developed because the existing health care system was not providing services to a large number of racial, philosophical and cultural minorities due to overcrowded hospitals, fear of legal entanglements, and insufficient experience with some of the "street" diseases involving these groups. The clinics have shown that adequate medical care can be provided at minimal cost utilizing non-professional, paraprofessional and professional staff. However, there are also problems and limitations with free clinics that must be explored.

In Bloomfield et al. (1971), the Health Policy Advisory Center made the following observations concerning these limitations and shortcomings:

1) Free clinics are not successful in eliminating some of the principle disadvantages of outpatient departments; waiting time is long, there are no appointments, follow-up is shoddy, continuity of care is almost impossible.

2) Free clinics are just as dependent on a limited supply of doctors despite their emphasis on skills transfer.

3) Free clinics, because of limited resources, must make serious trade-offs; for example, if quality care is to be given to each patient, then fewer patients can be seen.

4) Free clinics may demystify medicine, by removing the doctors' white coats and by taking away some of their "professional" prerogatives, but they often fall short of educating patients

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about their illness or about the politics of the health system.

5) Free clinics, by and large, have not been able to overcome the obstacles to community/worker control.

Confrontation between free clinics and the existing health care establishment in the United States has been far from predictable. For example, the American Medical Association Committee on Health Care of the Poor and Community Health Care (composed primarily of privately practicing physicians) stated the following in a 1972 report:

> Some free clinics are well staffed with physicians, nurses and other health personnel and are adequately equipped to provide high quality health care. Others, however, have experienced staffing and operational difficulties and admittedly are providing limited services of less than optimal quality. Many clinics recognize that they have deficiencies of varying degrees and generally are attempting within their limited resources to make improvements. Examples of deficiencies are lack of continuity in care, inadequate records, and no referral mechanism for specialty and hospital services.

Since its inception, the Free Clinic Movement has been gaining momentum. It has been estimated that over two million people were patients of free clinics in 1972 alone. The AMA is receiving an increasing number of inquiries concerning its position on free clinics. Because of the medical profession's recognized responsibilities for improving medical care of all persons, the Council on Medical Service and its Committees on Health Care of the Poor and Community Health Care (1972) offer the following recommendations:

1) In recognition of the fact that there are an increasing number of free clinics providing varying degrees of medical and health care in settings acceptable to only some population segments, organized medicine at the national, State, and local levels should continue to provide assistance and work to improve the quality of care in such clinics.

2) Local medical societies could improve liaison by having members or staff available to offer advice and assistance in the development or improvement of medical and health services in free clinics.

3) To assure quality medical care to all segments of our society, it is hoped that individual physicians and other health professionals will cooperate with those free clinics that are striving to give adequate medical care. Cooperation may be through the actual provision of services on a regular basis, accepting clinical referrals, serving in an advisory capacity, or a combination of these.

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The American Medical Association has indicated that although they are generally supportive of free clinics, their main concern is the quality of care delivered. They cite lack of peer review, poor continuity of care necessitated by essentially volunteer physicians, long waiting room periods for medical care, and a variety of other factors as critical concerns regarding free clinics.

All of the criticism of the Free Clinic Movement, however, does not come from the more conservative elements of society. A major attack comes from members of the minority communities being served, as well as from members of the Free Clinic Movement. These groups contend that free clinics propagate a two-layered system of health care; namely, one level for the middle- and upper-classes, and another for the poor or disaffiliated. By treating minority members of society with a lower quality of care, pressure is removed from the existing medical system to change its health care delivery approach to include this population. A two-layered system of health care then is in contrast with the free clinic philosophy that quality health care be delivered to all members of society, regardless of economical, philosophical or cultural status. At present, it is estimated that there are 25 million members of the minorities toward whom the Free Clinic Movement is directed; however, even if expansion of the Free Clinic Movement continues, it is unlikely that the needs of these 25 million individuals can be met solely from this source of health care delivery.

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